DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE .	& MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155632		(X2) M A. BUII		ONSTRUCTION  00	(X3) DATE ( COMPL <b>09/14/2</b>	ETED	
		155652	B. WIN			09/14/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LODGE OF THE WABASH			VINCENNES, IN47591				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	Revisit (PSR) to Complaint IN00 7/12/11.  This visit was a conjunction with and State Licer Survey Dates: 12, 13, 14, 201  Facility number Provider number AIM number: 2  Survey team: Carole McDania Terri Walters RI Martha Saull RI 2011)  Census bed typ SNF/NF: 55  Residential: 17  Total: 72  Medicare: 5  Medicare: 5  Medicaid: 55  Other: 12  Total: 72	h the Recertification hasure Survey.  September 6, 7, 8, 9, 1  :: 001138 er: 155632 e00157070  el RN TC N N (9/6, 7, 8, 12, 13, 14, oe:	FO	0000	F0000Preparation and/or execution of this Plan of Correction does not constitut admission or agreement by t facility of the truth of the facts alleged or conclusion set fort the Statement of Deficiencies. The Plan of Correction is prepand/or executed solely because required by the law. Submissions of this response Plan of Correction is not a legal admission that a deficiency or that this State of Deficience was correctly cited and is als to be construed as an admission therest of the facility HFA or any employees, ager other individuals who draft or be discussed in this response Plan of Correction. In addition preparation and submission of this Plan of Correction does constitute an admission or an agreement of any kind by the facility of the truth of any fact alleged or the correctness of conclusions set forth in this allegation by the survey ager This Plan of Correction shall constittre this facility's credib allegation of compliance on obefore October 14, 2011	he s h in s. hared use it e and gal exists sy o not sion , the ats or may e and on, of not n e s any ancy.	
	Sample: 5						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AYXX12

Facility ID:

001138

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE ( A. BUILDING B. WING	OONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/14/2011	
	PROVIDER OR SUPPLIER		STREE* 723 E	RAMSEY RD ENNES, IN47591	.1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	L COMPLE	TION
IAG	These deficiend findings cited in IAC 16.2.	cies also reflect state a accordance with 410 9/20/11 by Suzanne			DAII	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/14/2011
NAME OF 1	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LODGE	OF THE WABASH			RAMSEY RD ENNES, IN47591	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must in have been found gor mistreating resistance had a finding nurse aide registry mistreatment of resistance of their property; a has of actions by a employee, which is service as a nurse the State nurse aide authorities.  The facility must eviolations involving abuse, including in and misappropriate reported immediate the facility and to with State law through (including to the Sagency).  The facility must halleged violations and must prevent the investigation is the results of all in reported to the addrepresentative and accordance with State survey and working days of the violation is verified.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or genered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing  Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification  ave evidence that all are thoroughly investigated, further potential abuse while in progress.  Investigations must be ministrator or his designated of to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective			
	the facility faile allegation was for 1 of 1 allega	view and record review,	F0225	F225The facility does not en individuals who have been for guilty of any form of mistreatment, nor does the femploy any persons with ne findings on the nurse aide	ound

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155632	1			09/14/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER						
10005	OF THE WAR DAOL			1	RAMSEY RD		
LODGE	OF THE WABASH			VINCE	NNES, IN47591		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					registry.An all staff training o	n the	
	Findings includ	e:			abuse prohibition and report	ing	
		-			policy was conducted on		
	On 0/0/11 at 0:	26 A M Dooidont #9			September 23, 2011 rgarding		
		36 A.M., Resident #8			abuse practice of the facility.		
		d. She indicated CNA			unusual occurrence reporting	g to	
	#1 ignored her,	and ignored her call			State and the facility abuse	_	
	light. Resident	#8 indicated CNA #1			protocol was reviewed by the		
	won't answer h	er questions or talk to			HFA, Director of Nursing and Business Office Manager on		
		#8 indicated she did			September 23, 2011 to inclu		
		The resident indicated			what to report, when to repo		
	_	t assist her in the			interviewing appropriate staf		
					residents.In accordance with		
	dining room at				facility policy and the law, the	e HFA	
	_	nore her there also.			or designee does report		
	Resident #8 ind	dicated CNA #1 was			allegations within 24 hours o	f an	
	very nice to oth	er residents.			incident as may be appropria		
	-				The facilitya buse policy and		
	On 9/8/11 at 9:	30 A M the			reporting will be provided to	staff	
		and the Director of			at monthly meetings for six		
					months. The resident right		
	• , ,	were made aware of			regarding abuse will be revie		
	_	At this time the facility			with residents during the mo resident council meetings.No		
	indicated they v	would address the			other resident voiced concer		
	allegation.				regarding staff #1. The facili		
					investigation into resident #8	-	
	On 9/13/11 at 1	0:00 A.M., the facility			complaint included interview		
	allegation inves	stigation report			residents and staff. In this c	ase,	
	_	llegation of 9/8/11 was			the facility had sufficient		
		•			information to make a reason		
		investigation included			and prudent deccision regard	~	
		n Resident #8, CNA			the disposition of this matter		
		nt Director of Nursing			Additional staff interviews did	not נ	
	(ADON), and 8	other residents at the			appear to be warranted or	daas	
	facility. Docum	entation was lacking of			necessary. The facility policy		
	_	views except the			not sate that all persons will		
		ng this allegation.			inerviewed. The policy indic persons who may have	aits	
	, ibort rogardii	ig the diogation.			knowledge of the incident ma	av he	
					interviewed. The facility sha		
			1		in the facility of a		

001138

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155632 09/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 723 E RAMSEY RD LODGE OF THE WABASH VINCENNES, IN47591 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE On 9/13/11 at 1:45 P.M., during conduct a reasonably thorough investigation as it did in this interview with Administrator, the case. The policy does not require Administrator was made aware of the interviews with all persons as this lack of other staff interviewed for a is not reasonable or necessary in thorough investigation. At this time many cases. The facility social worker will meet with resident #8 the Administrator indicated she had one time per week for four weeks interviewed some CNAs but didn't regarding staff relationships. The write it down. HFA will monitor compliance and report any negative findings to the The facility's "Resident Safety Abuse Quality Assurance committee for six months. Statement," last revision dated 1/11, was received and reviewed on 9/13/11 at 9: 40 A.M. This policy included, but was not limited to: "....The Quality Assurance Manager and /or supervisor on duty will interview the residents as well as any nursing, housekeeping, laundry, dietary, activity, or social service staff, any visitors, or others who may have knowledge of the occurrence or who may have been in the vicinity at the time the incident happened...." This deficiency was cited on 7/12/11. The facility failed to implemenet a systemic plan of correction to prevent further recurrence. 3.1-28(d)

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155632	A. BUILDING			09/14/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RAMSEY RD		
LODGE	OF THE WABASH				NNES, IN47591		
EODGE OF THE WADAOTT				VINCEI	NNES, IN47591		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0226		evelop and implement					
SS=D		d procedures that prohibit					
		lect, and abuse of residents					
		ion of resident property.			FOOCTH - filit - h dl		10/11/2011
		view and record review,	F0	226	F226The facility has develop		10/14/2011
	the facility failed	d to ensure the facility			and implemented written poli		
	abuse policy wa	as followed for 1 of 1			and procedures that prohibit mistreatment, neglect and at	NICO	
	allegation of ab	use reported in the			of residents. The facility doe		
	sample of 5. R	•			employ individuals who have		
	campie or or in				been found guilty of any form		
	Eindings includ	0:			mistreatment, nor does the fa		
	Findings include:				employ any persons with neg	gative	
					findings on the nurse aide		
		36 A.M., Resident #8			registry.An immediate		
	was interviewe	d. She indicated CNA			investigation of this incident		
	#1 ignored her,	and ignored her call			conducted to include intervie	wing	
	light. Resident	#8 indicated CNA #1			staff and residents. The		
	_	er questions or talk to			employee was suspended pe		
		#8 indicated she did			protocol pending investigation There was no evidence of ha		
					to the resident. The facility to		
	-	The resident indicated			immediate, prudent action ar		
		t assist her in the			conducted an investigation in		
	dining room at				the complaint. The facility		
	continues to igr	nore her there also.			obtained sufficient informatio	n to	
	Resident #8 ind	dicated CNA #1 was			make a reasonable and prud	ent	
	very nice to oth	er residents.			decision regarding the dispos	sition	
	,				of this matter. Given the		
	On 9/8/11 at 9:	30 AM the			circumstances, the facility		
		nd the Director of			determined additional intervi	ews	
					were not necessary or		
	• • •	were made aware of			warranted. In good faith,		
	_	At this time the facility			additional interviews were conducted and no additional		
	indicated they v	would address the			information was obtained.In		
	allegation.				accordance with facility polic	v and	
					the law, the HFA or designed		
	On 9/13/11 at 1	0:00 A.M., the facility			report allegations with 24 hor		
	allegation inves				an incident. The HFA will		
	_	•			randomly question staff and		
	regarding the a	llegation of 9/8/11 was			residents during rounds twice	e per	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		f í			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155632	B. WIN			09/14/2	011
		1	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			RAMSEY RD		
LODGE	OF THE WABASH			1	NES, IN47591		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION)		TAG		£	DATE
		s investigation included			week regarding knowledge omisconduct and reporting	n any	
	1	m Resident #8, CNA			requirements. The facility at	ouse	
	1	nt Director of Nursing			policy and reporting will be	7	
	(ADON), and 8	other residents at the			provided to staff at monthly		
	facility. Docum	nentation was lacking of			meetings for six months. Th		
	other staff inter	rviews except the			resident right regarding abus		
	ADON regarding	ng this allegation.			be reviewed with the residen during monthly resident cour		
	On 9/13/11 at	1:45 P.M., during			meetings. The HFA will monit compliance and report any	or for	
	1	Administrator, the			negative findings to the Qual	ity	
		was made aware of the			Assurance committee for six		
		aff interviewed for a			months.		
		stigation. At this time					
	1	tor indicated she had					
		me CNAs but didn't					
		ine CivAs but didirt					
	write it down.						
	The facility's "F	Resident Safety Abuse					
	1	st revision dated 1/11,					
	1	and reviewed on					
		0 A.M. This policy					
	1	vas not limited to:					
	1						
	1	Assurance Manager					
		isor on duty will					
		esidents as well as any					
	nursing, housekeeping, laundry,						
		, or social service staff,					
	1	others who may have					
	knowledge of t	he occurrence or who					
	may have been	n in the vicinity at the					
	time the incide	nt happened"					
	This deficiency	was cited on 7/12/11.					
	1	ed to implement a					
	1						
	i systemic pian (	of correction to prevent					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	CON	TE SURVEY  MPLETED  1/2011
	PROVIDER OR SUPPLIER		723 E F	NDDRESS, CITY, STATE, ZIP RAMSEY RD NNES, IN47591	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	further recurrer 3.1-28(a)	ice.				
	3.1. <u>–</u> 3(u)					